Washington State
Department of Social
& Health Services

HRSA Health & Recovery
Services Administration

MSS Prenatal Screening Tool

CLIENT NAME	
DATE OF BIRTH	CLIENT ID

Instructions:	• An * asterisk indicates an MSS clinician (CHN, RD, BHS) needs to make the final determination on a client's risk criteria (A, B or C). • After screening the client for the MSS targeted risk factors, document the date(s) in the appropriate A, B or C column for any identified criteria, sign the last page noting who made the determination and assign the level of service.

TARGETED RISK FACTOR	DO NOT USE SHADED AREAS			RISK FACTOR CRITERIA
	A	**B**	**C**	
Race				**C.** American Indian, Alaska Native or non-Spanish speaking indigenous women from the Americas (e.g. women whose primary language is Mixteco, Mam, or Kanjobal, etc.)
				C. African American or Black
Prenatal Care				**A.** Greater than or equal to (≥) 14 and less than (<) **24 weeks** gestation **and no prenatal care** started at the time of screening.
				B. Greater than or equal to (≥) **24** weeks gestation when prenatal care started
				B. Greater than or equal to (≥) **24** weeks gestation **and no prenatal care** started at the time of screening.
Nutrition				**Food Insecurity**: **A.** Runs out of food before the end of the month or cuts down on the amount eaten to feed others
				Pre-pregnancy BMI: IOM = Institute of Medicine ***A.** Pre-pregnancy BMI less than **(<) 18.5** and weight gain **within** IOM guidelines.
				*C. Pre-pregnancy BMI less than **(<) 18.5** and weight gain **outside** of IOM guidelines
				A. Pre-pregnancy BMI **25.0 to 29.9**
				*A. Pre-pregnancy BMI greater than or equal to (≥) 30 and weight gain **within** IOM guidelines.
				*B. Pre-pregnancy BMI greater than or equal to (≥) 30 and weight gain **outside** of IOM guidelines
Medical				**Inter-pregnancy interval:** **A.** Current pregnancy conception less than (<) 9 months from the end of the last pregnancy
				Diabetes: **B.** History of gestational diabetes in the last pregnancy
				C. Pre-existing Diabetes- Type 1 or 2
				C. Current gestational diabetes
				Multiples: **C.** Currently pregnant with multiples (2 or more babies)
				Hypertension/Gestational Hypertension: **A.** Gestational Hypertension in past pregnancy
				C. Chronic Hypertension: Hypertension diagnosed prior to pregnancy or before 20 weeks gestation
				C. Current pregnancy induced hypertension (gestational hypertension) starting greater than 20 weeks gestation
				Low Birth Weight (LBW) or Preterm birth/labor/fetal death: **C.** Prior LBW infant (less than 5lb 8 oz) **and/or** premature infant (less than 37 weeks); Prior fetal death (fetus greater than 20 weeks gestation).
				C. Current pregnancy-diagnosed with **preterm labor** during this pregnancy or is on treatment or bed rest to prevent preterm birth.

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TARGETED RISK FACTOR	DO NOT USE SHADED AREAS			RISK FACTOR CRITERIA
	A	**B**	**C**	
Maternal Age				**A.** 16 years old at conception
				B. Up through age 15 at conception
				A. **35** years of age or older at conception **and** this is not her first pregnancy **and** she did not use assisted reproductive technology (ART) for this pregnancy
				B. **35** years of age or older at conception **and** one of the following: (1) First pregnancy (2) Current pregnancy via assisted reproductive technology (ART)
Maternal Tobacco Use				**A.** Quit smoking/using tobacco no more than 3 months prior to pregnancy or upon diagnosis of pregnancy.
				B. Smokes and/or uses tobacco during pregnancy
Alcohol and Substance Abuse or Addiction				***B.** **Actively engaged** in alcohol/drug **treatment** program and has not used for greater than or equal to **(≥) 90 days**.
				*B. **Stopped use** of alcohol (see clarification table), illicit substances, or non-prescriptive use of prescriptive drugs following pregnancy diagnosis and has not used for more than or equal to **(≥) 90 days**
				*C. **Stopped use** of alcohol (see clarification notes), illicit substances, or non-prescriptive use of prescriptive drugs following pregnancy diagnosis and has not used for less than **(<) 90 days**
				*C. **Any use** of alcohol, illicit substances, or non-prescriptive use of prescriptive drugs **once the client knows she is pregnant**.
Mental Health Severe Mental Illness (SMI) and Perinatal Mood Disorder				*** A.** **No history** of mental health diagnosis, but answers "Yes" to "In the last month, have you felt down, depressed or hopeless?" or showing potential symptoms of depression, but has **negative score on standardized** depression **screening** tool. i.e. Edinburgh, CES-D
				*B. **History of** mental health treatment but is stable, **or** history of postpartum depression with previous pregnancy, and **negative score on standardized** depression screening tool.
				*B. **Current** mental health diagnosis and is **engaged** in mental health treatment
				*C. Mental health symptoms of depression are evidenced by **positive score** on standardized depression screening tool
				*C. Client has a **mental health diagnosis** and exhibits **active symptoms** which interfere with general functioning
Developmental Disability				***A.** Severe developmental disability which could impact the woman's ability to take care of herself during the pregnancy or an infant, but has **adequate** support system, and **demonstrates** evidence of follow through with health care appointments/advice and self care
				*C. Severe developmental disability which impacts the woman's ability to take care of herself during the pregnancy or an infant and has an **inadequate** support system or **does not demonstrate** evidence of follow through with health care appointments/advice and self care
Intimate Partner Violence				**B.** In the last year, the woman's intimate partner or father of baby (FOB) has committed or threatened physical/sexual violence against her

☐ Check this box to acknowledge all the MSS targeted risk factors have been screened for and initial _____

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Screen date _____ Completed by _____ Level of service _____

Screen date _____ Completed by _____ Level of service _____

Screen date _____ Completed by _____ Level of service _____

Level of Service (available during pregnancy through two months post pregnancy):
Basic = No targeted risk factor or A level risks and no Bs or Cs
Expanded = At least one B and no Cs
Maximum = At least one C